Community Hospital Task Force II
Meeting #3 Notes
December 12, 2007
Rhode Island Department of Labor and Training
Building 73, John O. Pastore Complex, Cranston, RI

Commissioner Koller called the meeting to order at 5:04pm. He introduced Bruce Tucker, board member from Newport Hospital, as Lifespan's representative to the task force. Commissioner Koller asked the task force members to identify themselves.

Commissioner Koller discussed Attachment 2 regarding the updated workplan for the task force. The workplan is based on the elements of a payment system and breaks down the discussion over the coming months. Commissioner Koller explained that his goal would be to discuss policy adjuster weights for certain DRG's and potentially Non-DRG-specific policy-based add-ons by January 7, 2008. He clarified that a policy adjuster that increases payment in one area could mean that a decrease in payment for other areas.

Commissioner Koller discussed the report in the newspaper about the budget request from the Department of Human Service. The budget request had information in it regarding a change in the Medicaid hospital inpatient payment system. Commissioner Koller reassured the task force that the budget request is flexible, and that all parties agree that the budget submission will reflect the recommendations of the task force.

Discussion of the workplan by the task force

- Will the task force choose DRG weights? Kevin Quinn clarified that the task force will recommend a DRG grouper that comes with a set of weights. If, after financial modeling, the weights seem to favor or disfavor specific care categories, policy adjusters can be implemented to correct any imbalances the state wishes to correct.

- Financial modeling is important to determine what the impact will be. Will we have time to model and make decisions by January 10? Commissioner Koller stated that the Governor and Lieutenant Governor charged the task force with determining a DRG grouper based on a set of principles, not on financial modeling. There is room to correct financial issues after a payment system is chosen.

- Is this budget neutral? Commissioner Koller stated that task force recommendations will drive the budget discussion, but ultimately, the decision on the budget impact will be decided by the legislature. Additionally, the task force recommendation will influence the budget submission, not a budget request that was written before the task force convened.

- The design phase of the Medicaid payment system will involve a working group of hospitals. The Community Hospital Task Force will provide recommendations for the direction of the design phase. The length of the implementation phase will depend on how quickly the Medicaid information system can adopt the new payment system.

Options for Care-Based Inpatient Payment Methodology Based on Diagnosis Related Groups and Task Force Discussion (Kevin Quinn, ACS)

Mr. Quinn explained the genesis of the discussion paper drafted for the Department of Human Services that was distributed to the task force at the previous meeting. Mr. Quinn then discussed the general care breakdown of the national Medicaid population, highlighting the fact that Medicaid is a large payer for neonatal care, pediatric medical care, and pediatric mental health care. Mr. Quinn reviewed the function of a DRG-based payment methodology and discussed what DRG groupers are used by other states. Mr. Quinn compared select, relevant choices for DRG groupers against the set of principles selected by the task force.

Discussion on DRG options by the task force:

- What is it that states choose? Mr. Quinn clarified that states choose a DRG grouper, which gives a defined set of designations (each designation is referred to as a DRG) for the reason for hospital treatment, and case-mix values (also called DRG weights), that assign a relative weight to a DRG which then allows for payment to be calculated for the case. Normally, case-mix values are assigns as part of the DRG grouper, so a state does not need to create its own values.

- Is the effect of a policy adjuster felt on a statewide level or on an institutional level? Mr. Quinn explained that a policy adjuster would affect the payment on a statewide level. However, a policy adjuster may have a greater or lesser effect on a specific hospital based on that that hospital's mix of cases. For example, a policy adjuster that dramatically lowers the payment for mental health will be felt very strongly by a hospital that only provides mental health services.

- Would the state put a policy adjuster into statute? Mr. Quinn answered that an alternative mechanism could be to identify policy adjusters through an administrative rule process.

- Does any Medicaid program have a pay-for-performance element to their inpatient payment method now? Mr. Quinn responded that Pennsylvania may have some measures that are specific to the Medicaid population, and Arkansas might also have some.

- New payment methods, including any of these choices would require significant provider education, both on the hospital's administrative staff's part, as well as on the part of physicians and nurses.

- One point made by Mr. Quinn was that APR-DRG's have a complex logic. He clarified that by saying that the diagnosis and procedure codes that cause a case to be classified as a certain DRG require more detail to obtain the DRG designation.

- The current cost based system is used for both inpatient and outpatient and any new case-based method should work the same way.

- Any payment method that we select should be applicable to commercial insurers, since that is the charge of the task force.

- The payment should be considerate of the need for an annual adjustment, not just for inflation, but for a reduction in costs on the part of hospitals. If a hospital cuts costs because of the payment system, it should not be penalized by getting paid less the next year.

Commissioner Koller opened the floor to comments from the public in attendance. Tom Gough from Memorial Hospital stated that the implementation of a new payment system, especially in the form of APR-DRG, will necessitate an increase in hospital spending on education as well as additional FTE's for coding procedures. There are technical implications in merging the new DRG logic with a hospital's current IT infrastructure. Finally, the implementation of a system like DRG can accelerate the financial track of a hospital, including in a negative direction. Mr. Quinn responded that any consequences of a DRG and case mix values set on community hospitals can be fixed with a policy adjuster.

Brief comments on United Healthcare case-based methodology (B.J. Perry, United Health Care)

Commissioner Koller introduced B.J. Perry from United to discussed the case-based methodology that United uses to pay some hospitals in Rhode Island. Ms. Perry stated that United previously used a proprietary DRG grouper, but had problems with providers, specifically focusing on version control. For example, United might be using DRG version 23, while the hospital is using DRG version 16. While these are the same grouper system, the different versions led to conflicts in expected payment. Therefore, United has moved to MS-DRG with modification for their enrollee population. Since MS-DRGs are designed for a Medicare population, United has created specific carve-outs in certain care categories

to account for the failings in the MS-DRG system, and pays for some services using a per diem method.

Steve Lonardo from Blue Cross/Blue Shield Rhode Island (BCBSRI) stated that while BCBSRI pays hospitals on a per diem basis, records are run through the AP-DRG system for internal tracking. Mr. Lonardo stated that would not consider using MS-DRGs or a variant thereof for their non-Medicare age population.

Review principles for Case-Based Methodology (Commissioner Koller)

Commissioner Koller, using a slide prepared by Kevin Quinn, led a discussion comparing the DRG variants to the principles for a payment system as ranked by the task force in November. Discussion points included:

- The DRG system is one that gives hospitals incentives to lower cost. If the hospitals do lower costs, the system should be set up to ensure that payment is not lowered simply because hospital costs are lower.

- How many different payment systems do hospitals currently have to deal with and does the task force want to increase that number or decrease that number?

- Should the task force be examining the variants with an eye toward community hospitals?

- How should capital allowances by considered? Mr. Quinn stated that unlike Medicare, which includes a specific add-on, many states roll the capital allowance into the base rate, since Medicaid tends to be a smaller payer for hospitals.

- What coding changes will need to be made? It is dependent on the DRG variant that is chosen, if more specificity results in higher payment, than coders will do more work to dig into Dx and Px codes.

Commissioner Koller asked that the task force go around the table and suggest a non-binding choice of a preferred DRG variant for Rhode Island Fee for Service Medicaid Hospital Inpatient payment. Koller also asked for qualifying statements of pros and cons for DRG variants.

9 members of the task force responded with the following votes: APR-DRG - 5, AP-DRG - 1, MS-DRG - 1, No Answer - 2.

Discussion of AP-DRG:

It is already in use by one commercial payer, so a level of consistency could be maintained.
It is an earlier version of DRGs and was updated and modernized by the APR-DRG.

Discussion of APR-DRG:

Can it be easily applied to the commercial payers?
The system is set up to work now without carve-outs or tinkering by the state.
The task force does not know what costs of the system will be on the hospitals.
How much more value would APR-DRGs give the state?
Can APR-DRG's be integrated into hospitals systems?
Would the complexity of APR-DRG's lead to gaming of the system by coders?

Discussion of MS-DRG:

There are too many carve-outs necessary, because the system is not designed for a Medicaid population.
BCBSRI would not consider using MS-DRG for a non-Medicare population.

Commissioner Koller adjourned the meeting at 7:30pm